



**Canadian Nurses  
Protective Society**

**infoLAW<sup>®</sup>**

## **Consent for CPR**

Vol. 15, No. 2,  
April 2006

### **CPR is treatment**

The combination of chest compressions, artificial ventilation and medications is commonly referred to as CPR (cardiopulmonary resuscitation). Because of its potential benefit if implemented immediately, CPR has become a default treatment for cardiac arrest in many institutions, meaning that it will be implemented in all cases of cardiac arrest unless there is an explicit order against it. Unfortunately, CPR can revive only some patients. Like other medical interventions, it will not benefit every patient and can result in undesired injury.

When a patient declines CPR or will not benefit from it, a Do Not Resuscitate (DNR) order can be written. Health care facilities commonly have a policy setting out the process of obtaining a DNR order, the form it is to take, and the method for disseminating this information to the health care team. However, a DNR order on its own lacks specificity and could be misinterpreted to mean 'do not treat.' A plan of treatment, which may include a 'no CPR' order, documented on the patient record should eliminate any ambiguity.<sup>1</sup> For example, a terminally ill patient may decline chest compressions, intubation, and resuscitation medications when the end of his life naturally occurs but request that his 'no CPR' order be suspended while he undergoes a surgical procedure to assist with his comfort. It is reasonable to suspend the 'no CPR' order in the intra- and post-operative period for reversible problems directly related to the surgery or anaesthesia. A plan of treatment which outlines this, along with the appropriate consent for surgery, will ensure the patient receives care appropriate to the situation.

### **What if a patient does not want CPR but his family does?**

A patient who has the capacity to consent to treatment is one who understands the nature of the decision to be made and the consequences of his decision, including the decision to decline treatment. A capable patient is the only one with legal authority to accept or decline CPR, in spite of family disagreement or distress. If this patient then becomes gravely ill and incapable of making treatment decisions, his previously expressed wishes on resuscitation must be followed.<sup>2</sup>

### **What if the patient demands CPR but it would be ineffective?**

Although a patient or substitute decision-maker consents to, or refuses, treatment, health professionals are required to use their skill, experience and knowledge to benefit the patient. Treatment options and alternatives should be presented to a patient and discussed; then an agreed plan of care can be devised. The plan of care must be based on the patient's current and anticipated health status, current best practices and goals of treatment. Since CPR is treatment, it does not have to be offered to all patients. Health care professionals cannot be forced to provide treatment that is contrary to their professional obligations. When it is clear to health professionals that CPR would not be effective, sensitivity and diplomacy must be used to present appropriate elements in the plan of care to the patient, knowing the plan cannot be acted upon without the patient's consent.

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**More than  
liability  
protection**

## What should I do when the doctor refuses to comply with the hospital policy on CPR?

It is medically inappropriate and legally risky to do CPR on a patient who would not benefit from it or who has decided against it. When a doctor fails to comply with the CPR policy, the reason for not doing so should be determined. If a satisfactory resolution cannot be found, management must be notified that their policy, designed to provide good patient care, is not being followed.

Failing to ensure medical staff are adhering to a policy designed to deliver good care to patients can be negligence on the part of the health care facility, as in the case where the court observed, "...when a hospital brings in a new policy aimed at better care for patients, it is under a duty to see all understand and work towards achieving this higher standard."<sup>3</sup>

## What can the health care team do to achieve the best patient care?

- Ascertain who has the legal authority to consent to treatment. If it is a substitute decision-maker, make sure the team members know this by including it in the patient's chart;
- Devise a plan of care based on the patient's current and anticipated status. A plan of care may provide for the withholding or withdrawal of treatment in light of the patient's health condition and the patient's informed consent to the plan of care;
- Document the actions of the health team properly. Use the format approved by your facility. During a resuscitation, the usual documentation standard (the nurse who does the care records the care) can be suspended if a recorder is designated;
- Work towards improving the policy or the professional practice if the health facility's DNR or CPR policy does not reflect current best practice, lacks specificity, or is ignored.

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1. *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 2 contains the following definitions:

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.

"plan of treatment" means a plan that:

- a. is developed by one or more health practitioners,
  - b. deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
  - c. provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition.
2. For more detail, refer to *infoLAW*, Consent to Treatment: The Role of the Nurse (Vol. 3, No. 2, December 1994) and *infoLAW*, Consent for the Incapable Adult (Vol. 13, No. 3, December 2004).
  3. *Comeau v. Saint John Regional Hospital* (1999), 221 N.B.R. (2d) 201 at para. 53 (Q.B.), aff'd (2001) 244 N.B.R. (2d) 201 (C.A.).

*N.B. In this document, the feminine pronoun includes the masculine and vice versa.*

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